Complete Summary

GUIDELINE TITLE

Adult preventive services (ages 50 - 65+).

BIBLIOGRAPHIC SOURCE(S)

Michigan Quality Improvement Consortium. Adult preventive services (ages 50-65+). Southfield (MI): Michigan Quality Improvement Consortium; 2008 Sep. 1 p.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Michigan Quality Improvement Consortium. Adult preventive services (ages 50-65+). Southfield (MI): Michigan Quality Improvement Consortium; 2006 Sep. 1 p.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Preventable diseases and conditions, including:

- Overweight/obesity
- Hypertension
- Dyslipidemia
- Diabetes mellitus
- Colorectal cancer
- Glaucoma
- Osteoporosis
- Cervical cancer

- Breast cancer
- Prostate cancer
- Tetanus
- Diphtheria
- Pertussis
- Varicella infection
- Herpes zoster infection
- Influenza
- Pneumococcal pneumonia
- Depression
- Alcohol and/or substance abuse
- Tobacco abuse
- Domestic violence
- Sexual abuse

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Obstetrics and Gynecology
Optometry
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Plans
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To achieve significant, measurable improvements in the management of adult preventive services (ages 50 to 65+) through the development and implementation of common evidence-based clinical practice guidelines
- To design concise guidelines that are focused on key management components of adult preventive services (ages 50 to 65+) to improve outcomes

TARGET POPULATION

- Adult patients ages 50 to 64 years
- Adult patients age 65+ years

INTERVENTIONS AND PRACTICES CONSIDERED

Screening/Prevention

1. Health maintenance exam including height and weight; risk evaluation and counseling (e.g., nutrition, physical activity, tobacco use, sexual health); safety assessment (e.g., domestic violence, seat belts, firearms); behavioral assessment (e.g., depression, suicide threats, alcohol/drug use)
2. Blood pressure monitoring
3. Screening for the following diseases/conditions:
    - Dyslipidemia
    - Diabetes mellitus
    - Osteoporosis
    - Colorectal cancer
    - Glaucoma
    - Cervical cancer
    - Breast cancer
    - Prostate cancer

4. Immunizations (tetanus diphtheria acellular pertussis/tetanus-diphtheria [TdaP/Td], varicella, zoster, influenza, pneumonia)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Michigan Quality Improvement Consortium (MQIC) project leader conducts a search of current literature in support of the guideline topic. Computer database searches are used to identify published studies, existing protocols and/or national guidelines on the selected topic developed by organizations such as the American Diabetes Association, American Heart Association, American Academy of Pediatrics, etc. If available, clinical practice guidelines from participating MQIC health plans and Michigan health systems are also used to develop a framework for the new guideline.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence for the Most Significant Recommendations

A. Randomized controlled trials
B. Controlled trials, no randomization
C. Observational studies
D. Opinion of expert panel

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Using information obtained from literature searches and available health plan guidelines on the designated topic, the Michigan Quality Improvement Consortium (MQIC) project leader prepares a draft guideline to be reviewed by the medical directors' committee at one of their scheduled meetings. Priority is given to recommendations with [A] and [B] levels of evidence (see "Rating Scheme for the Strength of the Evidence" field).

The initial draft guideline is reviewed, evaluated, and revised by the committee resulting in draft two of the guideline. Additionally, the Michigan Academy of Family Physicians participates in guideline development at the onset of the process and throughout the guideline development procedure. The MQIC guideline feedback form and draft two of the guideline are distributed to the medical directors, as well as the MQIC measurement and implementation group members, for review and comments. Feedback from members is collected by the MQIC project leader and prepared for review by the medical directors' committee at their next scheduled meeting. The review, evaluation, and revision process with several iterations of the guideline may be repeated over several meetings before consensus is reached on a final draft guideline.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

When consensus is reached on the final draft guideline, the medical directors approve the guideline for external distribution to practitioners with review and comments requested via the Michigan Quality Improvement Consortium (MQIC) health plans (project leader distributes final draft to medical directors' committee, measurement and implementation groups to solicit feedback).

The MQIC project leader also forwards the approved guideline draft to appropriate state medical specialty societies for their input. After all feedback is received from external reviews, it is presented for discussion at the next scheduled committee meeting. Based on feedback, subsequent guideline review, evaluation, and revision may be required prior to final guideline approval.

The MQIC Medical Directors approved this updated guideline in September 2008.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The level of evidence grades (A-D) are provided for the most significant recommendations and are defined at the end of the "Major Recommendations" field.

Health Assessment Screening, History, and Counseling

Ages 50 to 64 years

One health maintenance exam (HME) every 1 to 3 years according to risk status **[D]**

Age 65+ years

One HME at least every 2 years

Each HME should include:

- Height, weight, and body mass index (BMI)
- Risk evaluation and counseling (nutrition, obesity, physical activity, dental health, tobacco use **[A]**, immunizations, human immunodeficiency virus (HIV) prevention **[B]**, sexually transmitted infections prevention **[B]** and sexual

health, sexual abuse, polypharmacy including over-the-counter and herbal preparations when appropriate, sun exposure)
- Safety (domestic violence, seat belts, helmets, firearms, smoke and carbon monoxide detectors)
- Behavioral assessment (depression, suicide threats, alcohol/drug use, anxiety, stress reduction, coping skills)

Blood Pressure Monitoring [A]

Ages 50 to 65+ Years

At every office visit and, at minimum, every 2 years. If blood pressure (BP) 120-139/80-89 or higher and/or presence of risk factors, more frequent monitoring is recommended.

Cholesterol and Lipid Screening [B]

Ages 50 to 65+ Years

Measure a complete fasting lipoprotein profile (i.e., total cholesterol, low-density lipoprotein cholesterol [LDL-C], high-density lipoprotein cholesterol [HDL-C], and triglycerides) every 5 years if initial test is normal in low-risk adults. If multiple risk factors are present, more frequent measurements are recommended.

Diabetes Mellitus Screening

Ages 50 to 65+ Years

Fasting plasma glucose (FPG) every 3 years beginning at age 45. FPG may be performed earlier in patients at increased risk of diabetes (e.g., those with BMI $\geq$ 25, family history and high-risk ethnic groups - African Americans, Native Americans, Hispanics, and Pacific Islanders)

Colorectal Cancer Screening [B] for Average Risk Adults

Ages 50 to 65+ Years

Fecal occult blood test (FOBT) annually and/or sigmoidoscopy every 5 years; or double contrast barium enema every 5 years; or colonoscopy every 10 years

Glaucoma Screening [C]

Ages 50 to 64 Years

No requirement unless high risk (e.g., increased intraocular pressure, family history, African Americans, people who have diabetes, myopia, regular/long-term steroid use, previous eye injury)

Age 65+ Years

Every 2 years; screen annually if high risk

Osteoporosis Screening [C]

Ages 50 to 64 Years

- Men or women on chronic glucocorticosteroids (prednisone > 7.5 mg/day, or equivalent, for > 6 months) and those who have received a solid organ transplant > 2 years ago should be screened.
- Post-menopausal women with any of the following: personal history of fracture without substantial trauma ≥ age 40; family history of fracture (hip, wrist or spine in first-degree relative ≥ age 50); current smoking; weight in lowest quartile (< 127 lbs); and frailty.
- Bone Mineral Density (BMD) test once for initial diagnosis. Do not repeat test more frequently than every 2 years (per Michigan Quality Improvement Consortium [MQIC Osteoporosis guideline]).

Age 65+ Years

Women age >65 regardless of risk factors

Cervical Cancer Screening [A] Pap Smear

Ages 50 to 64 Years

At least every 3 years, unless high risk (i.e., history of abnormal Pap results, sexually transmitted diseases, or HIV; sexual activity before age 18 or multiple partners; vaginal spotting or bleeding between periods, after intercourse, or after menopause; tobacco use) (Consider discontinuation for patients with surgical removal of cervix for benign conditions).

Age 65+ Years

May discontinue after age 65, based on clinical judgment according to risk status

Mammography [A] and Clinical Breast Exam [C]

Ages 50 to 70 years

Every 1 to 2 years

Age 70+ years

Shared decision-making after age 70

Prostate Cancer Screening [D]

Ages 50 to 65+ years

Age 50 to 65 years, shared decision-making for digital rectal examination (DRE) and/or prostate specific antigen (PSA) testing

Immunizations

Tetanus Diphtheria Acellular Pertussis/Tetanus-diphtheria (TdaP/Td) [A]

Ages 50 to 64 Years

TDaP once after age 11, then Td every 10 years

Age 65+ Years

Td every 10 years

Varicella [C]; Zoster [C]

Ages 50 to 65+ Years

Varicella as indicated by the Advisory Committee on Immunization Practices (ACIP) guidelines. Single dose zoster vaccine at age $\geq$ 60 years

Influenza [B]

Ages 50 to 65+ Years

Annually

Pneumococcal Vaccine [B]

Ages 50 to 64 Years

No requirement, unless high risk

Age 65+ Years

Once at age 65; booster may be needed after 5 years

Definitions:

Levels of Evidence for the Most Significant Recommendation

A. Randomized controlled trials
B. Controlled trials, no randomization
C. Observational studies
D. Opinion of expert panel

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence is provided for the most significant recommendations (see "Major Recommendations" field).

This guideline is based on several sources, including: *The Guide to Clinical Preventive Services 2007, Recommendations of the U.S. Preventive Services Task Force* (http://www.ahrq.gov/clinic/prevenix.htm) and the *Advisory Committee on Immunization Practices (ACIP) 2006 Immunization Recommendations* (www.cdc.gov).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Through a collaborative approach to developing and implementing common clinical practice guidelines and performance measures for adult preventive services (ages 50 to 65+), Michigan health plans will achieve consistent delivery of evidence-based services and better health outcomes. This approach also will augment the practice environment for physicians by reducing the administrative burdens imposed by compliance with diverse health plan guidelines and associated requirements.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline lists core management steps. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Approved Michigan Quality Improvement Consortium (MQIC) guidelines are disseminated through email, U.S. mail, and websites.

The MQIC project leader prepares approved guidelines for distribution. Portable Document Format (PDF) versions of the guidelines are used for distribution.

The MQIC project leader distributes approved guidelines to MQIC membership via email.

The MQIC project leader submits request to website vendor to post approved guidelines to MQIC website (www.mqic.org).

The MQIC project leader completes a statewide mailing of the comprehensive set of approved guidelines and educational tools annually. The guidelines and tools are distributed in February of each year to physicians in the following medical specialties:

- Family Practice
- General Practice
- Internal Medicine
- Other Specialists for which the guideline is applicable (e.g., endocrinologists, allergists, pediatricians, cardiologists, etc.)

The statewide mailing list is derived from the Blue Cross Blue Shield of Michigan (BCBSM) provider database. Approximately 95% of the state's M.D.'s and 96% of the state's D.O.'s are included in the database.

The MQIC project leader submits request to the National Guideline Clearinghouse (NGC) to post approved guidelines to NGC website (www.guideline.gov).

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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DATE RELEASED

2005 Jul (revised 2008 Sep)

GUIDELINE DEVELOPER(S)

Michigan Quality Improvement Consortium - Professional Association

SOURCE(S) OF FUNDING

Michigan Quality Improvement Consortium

GUIDELINE COMMITTEE

Michigan Quality Improvement Consortium Medical Director's Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Physician representatives from participating Michigan Quality Improvement Consortium health plans, Michigan State Medical Society, Michigan Osteopathic Association, Michigan Association of Health Plans, Michigan Department of Community Health, and Michigan Peer Review Organization

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Standard disclosure is requested from all individuals participating in the Michigan Quality Improvement Consortium (MQIC) guideline development process, including those parties who are solicited for guideline feedback (e.g., health plans, medical specialty societies). Additionally, members of the MQIC Medical Directors' Committee are asked to disclose all commercial relationships as well.

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GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Michigan Quality Improvement Consortium Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on November 28, 2005. The updated information was verified by the guideline developer on December 19, 2005. This NGC summary was updated by ECRI on October 16, 2006. The updated information was verified by the guideline developer on November 3, 2006. This NGC summary was updated by ECRI Institute on November 26, 2008. The updated information was verified by the guideline developer on December 4, 2008.

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